~~Enclosure 3~~ As directed by State DOH Ruth Hughes 4/14/98



The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

Approval Date 4-20-98
Effective Date 1/1/98

Plan # 98-04
Supersedes Plan # N/A

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**
**State: MICHIGAN**

**METHODS OF PAYMENT OF REASONABLE COSTS -**
**INPATIENT HOSPITAL SERVICES**

I. Principle

A. Reimbursement Types

The Michigan Medicaid Program inpatient reimbursement system is applicable for inpatient hospital services rendered under the Medicaid and Crippled Children's programs and to recipients with dual Medicare-Medicaid eligibility.

Reimbursement for inpatient services rendered to recipients with dual Medicare-Medicaid eligibility will be the Medicaid amount less Medicare reimbursement, but not less than zero. Medicaid reimbursement will be limited to a maximum of the Medicare coinsurance and deductible amounts. For patients who have exhausted their Medicare Part A coverage, Medicaid will provide reimbursement for capital and direct medical education. Reimbursement for capital and direct medical education will be made according to the methodologies indicated in Sections I and J of 4.19-A , respectively. Medicaid will not pay capital or direct medical education costs for any other recipients with dual Medicare-Medicaid eligibility.

1. Diagnosis Related Groups

All hospitals participating in the Medical Assistance Program are reimbursed for operating costs based on Diagnosis Related Groups (DRGs). Exceptions are listed below.

2. Perspective Per Diem

The following groups of hospitals or units are reimbursed for operating costs on a prospective per diem basis:

- Freestanding rehabilitation hospitals which are excluded from the Medicare prospective payment system (PPS),
- Freestanding psychiatric hospitals which are excluded from the Medicare PPS, and
- Distinct-part psychiatric units of general hospitals which have been certified by Medicare and excluded from its PPS.

Services provided to patients in sub acute ventilator-dependent care units are reimbursed using a prospective per diem rate that includes capital and direct medical education costs.

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3. TEFRA Limited Cost Based

State-owned psychiatric hospitals, are reimbursed for allowable operating costs under Medicare Principle of Reimbursement with TEFRA limits applied.

4. Percent of Charge

Hospitals outside of Michigan that are not enrolled in the Michigan Medicaid Program are reimbursed for all costs (including capital) at a percentage of allowable charges. The cost of direct medical education is not reimbursed to hospitals outside of Michigan that are not enrolled in the Michigan Medicaid Program.

10-1-91

4a. Cost Reimbursement

The operating payment for services provided to Medicaid recipients in distinct part rehabilitation units will be made at full cost using Medicare principles of allowable costs.

5. Capital

Capital costs are reimbursed using a system based on allowable costs with occupancy limitations for some hospitals and units.

6. Direct Medical Education

Allowable direct medical education costs are reimbursed up to a maximum limit. The limit is described in Section III-J.

B. Lesser of Rate or Charges

Total payments for program inpatient services will be limited to the lesser of total payments or full charges, in the aggregate, for each hospital. If the aggregate program charges are less than total payments, the difference will be gross adjusted. This review and adjustment will occur coincident with adjustments for capital and direct medical education costs, at the facility fiscal year end.

C. Interim payments will be made in compliance with 42 CFR 413.60 et seq.

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II. Cost Reporting and Audit

A. Cost Reporting

Hospitals must complete and submit a cost report on the form and in the format designated by the Michigan Medical Services Administration (MSA) in accordance with the instructions related to the Medicaid Program. The hospital's cost report must:

- be HCFA-2552 forms (modifications or changes to meet program needs may be required),
- follow the Medicare Principles of Reimbursement Manual (HIM 15 and 15-1) and all applicable parts of 42 CFR Chapter IV,
- be prepared using the accrual method of accounting (unless an alternative method is approved by the MSA),
- be a separate cost report as well as distinct-part accounting for Medicare certified distinct-part units, and
- include all information necessary for proper determination of costs payable under the program including financial records and any needed statistical data.

For cost reporting purposes, the MSA requires each eligible hospital provider to submit periodic reports which generally cover consecutive 12 month periods of operation. Inpatient and/or outpatient cost reports must be filed within 90 days of the end of the hospital's cost reporting year. State owned hospitals must file cost reports within 180 days after the end of the State's cost reporting year.

Extensions of the filing period may be granted when exceptional circumstances establish good cause. If the hospital requests an extension in writing and documents the exceptional circumstances prior to the date due, extensions may be granted up to a maximum of 30 days. Failure to submit all necessary items and schedules will only delay processing and will result in a reduction of payment or termination as a provider.

Hospitals that fail to submit cost reports as defined previously will receive a delinquency letter from the MSA. If the cost report is not submitted within 30 days of the notice of delinquency, a second notice of delinquency will be issued. If the cost report is not submitted within 30 days of a second notice of delinquency, the provider's payments will be stopped. Restitution of withheld payments will be made by the State agency after receipt, and review, of an acceptable cost report.

[redacted] 12/28/90
TN No. 90-23 Date [redacted]
Supersedes TN No. 86-7 Date Appr. 12/6/91
Effective Date 10/1/90

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B. Audit

Audits are performed for Michigan inpatient hospital services provided after February 1, 1985 to determine program cost for capital and direct medical education using Medicare Principles of Reimbursement.

Once any appropriate limits are applied, the capital and direct medical education program cost is added to the amount approved as payment for the program operating cost to obtain a total amount approved. The total amount approved in a hospital's fiscal year is compared to the hospital's program charges. The lesser of amount approved or charges is then compared to the amount actually paid throughout the year to determine the amount overpaid or underpaid to the hospital.

HCFA-179 # 90-33 Date Rec'd 12/28/90
Supercedes 88-15 Date Appr. 12/6/91
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III. Payment Determination

The DRG reimbursement for operating expenses is:

*(Relative Weight x DRG Price) + Outlier Payment*

The patient is assigned to a DRG using the same DRG grouper version used to establish the relative weight.

A. Relative Weight:

A statewide relative weight is assigned to each DRG. The statewide relative weights calculated for the Michigan system utilize Medicaid and Children's Special Health Care Services inpatient claims for admissions between October 1, 1990 and September 30, 1992, paid by December 31, 1993; and hospital specific cost report data drawn from cost report years ending between October 1, 1991 and September 30, 1992.

The claims file was adjusted to:

- combine multiple billings for the same episode of service, including:
  - invoices from a single episode of service billed as a transfer from a hospital and an admission to the same hospital caused by a change of ownership and issuance of a new Medicaid ID number, and
  - invoices for a single episode of service billed as a transfer from a hospital and an admission to a hospital created from a merger of two or more hospitals and the assignment of patient bills from multiple hospitals to a single Medicaid ID number.

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- eliminate episodes with any Medicare reimbursement;
- assign DRG values to each episode using the Medicare grouper program (Version 11.0 that was effective October 1, 1993 for Medicare),
- restrict episodes ending in a transfer to another acute setting to those whose length of stay was at least equal to the arithmetic mean length of stay for the DRG (for DRGs 385, 385.1 and 456, all transfers were included),
- limit episodes to those from Michigan hospitals (provided that hospital cost report data are available for a period ending between October 1, 1991 and September 30, 1992 including hospitals that are no longer in operation),
- limit episodes to those with a valid discharge status (incomplete episodes were excluded - generally these are instances where there are invoices with discharge status "7" - additional page of a multiple page bill, with no initial claim containing a valid discharge),
- eliminate low day outliers (Low day outliers are those episodes whose length of stay is less than the published low day threshold for each DRG. The threshold was generally set at one day or at the 3rd percentile of length of stay. Since low day outliers are paid under a percent of charge method using the hospital's cost to charge ratio time charges, and do not receive a DRG payment, they are excluded from the weight calculations),
- adjust the charges for high day and/or cost outliers to approximate the charges for the non-outlier portion of the stay.

  A high day outlier's length of stay is greater than the high day outlier threshold for the DRG. The threshold is generally set at the lesser of the 97th percentile of the length of stay within each DRG or the mean length of stay for the DRG plus 30 days. Medicare values and the advice of medical experts were used to supplement the available data, in cases of an inadequate number of episodes to properly set weights and trim points.

  Adjusted charges representing an estimate of the non-outlier portion of charges for high day outliers are used for the relative weight and price calculations:

$$\frac{Charges \times Non\text{-}Outlier\ Days}{Non\text{-}Outlier\ Days + (0.6 \times Outlier\ Days)}$$

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A cost outlier's costs (i.e., charges times the hospital's operating cost to charge ratio) are greater than the larger of twice the DRG payment or $35,000.

Adjusted charges representing an estimate of the non-outlier portion of charges for cost outliers are used for relative weight and price calculations. The adjusted charges uses a cost threshold estimate as the greater of:

$$2 \times \text{Avg. Cost for the DRG}$$

or $35,000.

The cost threshold estimate is used to estimate the non-outlier portion of charges for the relative weight and price calculations. The cost ratio is each hospital's operating cost to charge ratio.

$$\text{Charges} - \frac{[(\text{Charges} \times \text{Cost Ratio}) - \text{Cost Threshold}] \times .85}{\text{Cost Ratio}}$$

If an episode is both a high day and a cost outlier, the lesser of the two adjusted charges is used in computing relative weights and DRG prices.

- bring all charges for admissions between October 1, 1990 and September 30, 1991 to the period of October 1, 1991 through September 30, 1992 using an inflation factor of 1.030,

- recognize hospital specific wage differences by dividing the charges for each hospital by a hospital specific cost factor.

Each hospital's cost adjustor is calculated as:

$$(0.9 \times \text{Wage Adjustor}) + 0.10$$

This formula is the algebraic derivation of:

$$(0.75 \times \text{Wage Adjustor}) + 0.25[(0.60 \times \text{Wage Adjustor}) + 0.40]$$

The formula is based on the assumption that approximately 75% of a hospital's operating costs are labor costs and that 60% of the remaining 25% of a hospital's operating costs vary with its labor costs.

Each hospital's wage factor is based on DRG audited wage per hour, obtained from HCFA, and freestanding DRG children's hospital reported wage data only. (Appeals of the HCFA wage data are not considered unless

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Data for current wage adjusters is submitted data taken from hospital cost reporting periods ending between October 1, 1993 and September 30, 1994. Factors from the following table will be used to neutralize for inflationary differences. The adjustors represent the employee cost component of the Data Resources, Inc. PPS-Type Hospital Market Basket index (first Quarter of 1995).

| FYE | Wage Data Inflation |
|---|---|
| 12/31/93 | 1.024 |
| 3/31/94 | 1.015 |
| 6/30/94 | 1.008 |
| 9/30/94 | 1.000 |

- remove indirect medical education charges by dividing by an adjustor for indirect education of :

$$1 + ([(\frac{Interns\ \&\ Residents}{Beds})^{0.5795} - 1] \times 0.715)$$

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Each hospital's Title XIX operating cost to Title XIX total charge ratio is obtained from file cost reports for fiscal years ending between October 1, 1991 and September 30, 1992. If the cost to charge ratio is greater than 1.0, then 1.0 will be used.

The cost for each episode is calculated by multiplying the charges for each episode by the Title XIX operating cost to Title XIX charge ratio for the hospital.

If two or more hospitals merged during the base year period and are now operating as a single hospital, a cost to charge ratio for the period after the merger will be computed using the combined cost report data from all hospitals involved in the merger.

The average cost for episodes within each DRG was calculated by dividing the sum of the costs of the episodes by the number of episodes within the DRG.

The relative weight for each DRG was calculated by dividing the average cost for episodes within each DRG by the average cost per episode for all episodes.

A table showing the relative weights, average lengths of stay, and outlier thresholds for each DRG appears in Appendix A.

Two sets of weights have been generated for the six (6) DRG classifications representing neonatal services (385-390). One set of weights is identified as "alternate weights" (385.1, 386.1, 387.1, 388.1, 389.1, and 390.1). These weights were calculated from episodes that were assigned to one of these DRGs, and include charges for services in an intensive care unit of one of the hospitals designated as having neonatal intensive care units. The remaining claims assigned to these DRGs are used for the other set of weights.